

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 003767	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 04/06/2015
NAME OF PROVIDER OR SUPPLIER REGENCY HOSPITAL OF NORTHWEST INDIANA		STREET ADDRESS, CITY, STATE, ZIP CODE 4321 FIR ST 4TH FL EAST CHICAGO, IN 46312		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	<p>INITIAL COMMENTS</p> <p>This visit was for the investigation of one State complaint.</p> <p>Date of survey: 4/6/2015</p> <p>Facility number: 003767</p> <p>Complaint #: IN00155609 Substantiated; no deficiencies related to allegations are cited.</p> <p>Regency Hospital of Northwest Indiana is in compliance with 410 IAC 15-1.5-1, Dietary Services and 410 IAC 15-1.5-6, Nursing Services, Hospital Licensure Rules.</p> <p>QA: cjl 04/28/15</p>	S 000		

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE